VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

July 30, 2010

Ms. Rachael Parker, Administrator
Starr Farm Nursing Center
98 Starr Farm Rd
Burlington, VT 05401

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on June 6, 2010. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING _____ B. WING _____	C 07/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARR FARM NURSING CENTER	98 STARR FARM RD BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 07/06/10 for 8 complaints.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F157 Resident #3's physician and family member were notified on 5/16/10 of the blistered sunburn. The nurses involved were in-serviced on notifying the physician and family with a change in condition. Resident nursing notes were reviewed for the past 30 days to determine physician notification of any change in condition and will be notified as needed by 7/30/10. Licensed nurses will be in-serviced on physician notification for change in condition and documenting resident change in condition in the 24 hour report by 7/30/10. Random audits will be completed 3 times a week by the nurse manager or designee for 3 months to ensure the physician has been notified for a resident change in condition. Results of these audits will be reported the PI committee and changes will be made as needed. The DNS is responsible for monitoring compliance. F157 POC Accepted 7/29/10 J. Hosmer RN/PMC to RN	7/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rachael Peck — 7/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to immediately consult the physician and inform the family regarding an injury with potential for requiring medical intervention for 1 resident (Resident #3). Findings include: 1. Per interview and record review, the facility failed to notify the physician and family member of an injury for Resident #3, who was observed by staff to have a blistered sunburn on 5/14/10. In an interview with the Activities Director and the infection control nurse at 2:30 PM on 7/6/10, Resident #3 was confirmed to have been at an outdoor activity from 11:15 AM to 12:00 noon on 5/13/10, which was described as a sunny day. In this same interview, the Director of Nurses (DNS) further confirmed that on 5/14/10 the staff noticed that Resident #3 had a blistered sunburn on at least one facial area and did not consult the physician or notify the family. Per record review, nursing notes indicated that on 5/16/10, the facility consulted Resident #3's physician regarding a sunburn, and also notified the responsible family member of the injury. The DNS confirmed that this notification was a full two days after staff noticed the sunburn.	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to meet professional standards for	F 281	F281 Resident #3's physician was contacted on 5/16/10 for a treatment for the blistered sunburn. The nurses involved were in-serviced on notifying the physician for a treatment order on 6/10/10.	7/30/10

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F 281	Continued From page 2 documentation of patient care at the time it was provided for 1 resident (Resident #3). Findings include: 1. Per interview and record review, the facility failed to document a complete assessment and document the application of topical medication for Resident #3, who was observed by staff to have a blistered sunburn on 5/14/10. In an interview on 7/6/10 at 1:40 PM, the Director of Nurses (DNS) confirmed that nursing staff had noticed a sunburn on resident #3's face on 5/14/10, one day after resident #3 had attended an outdoor activity on 5/13/10. The DNS further stated that nursing staff had applied Bacitracin ointment to the facial sunburn site over the next few days. Per record review and further interview, the DNS confirmed that there was no evidence in the medical record of nursing assessment or treatment of facial sunburn on 5/13/10, 5/14/10 or 5/15/10. Per record review, a nurse consulted Resident # 3's physician on 5/16/10 regarding a blistered facial sunburn and received a medical order to apply Silvadene ointment to the site twice daily for five days. In an interview on 7/6/10 at 2:30 PM, the DNS confirmed that documentation of assessment, consultation and treatment of a blistered sunburn first occurred on 5/16/10, a full two days after nursing staff had noticed the injury on 5/14/10. Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident nursing notes were reviewed for the past 30 days to determine any resident with a change in condition requiring a treatment intervention. The physician will be notified for a treatment order as needed by 7/30/10. Licensed nurses will be in-serviced on physician notification for change in condition requiring treatment orders by 7/30/10. Random audits will be completed 3 times a week by the nurse manager or designee for 3 months to ensure the physician has been notified for a resident change in condition. Results of these audits will be reported the PI committee and changes will be made as needed. The DNS is responsible for monitoring compliance. F281 POC Accepted 7/29/10 J Hosmer RN/P Nicotra RN	
F 362 SS=B	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support	F 362		

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F 362	Continued From page 3 personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to have sufficient support personnel to carry out dietary assistance for 1 applicable resident (Resident #1). Findings include: 1. Per interview on 07/06/10 at 11:20 AM, Resident #1 stated that meals are served too slow and being waited on takes too long. Per observation on 07/06/10 at the noon meal, the following was observed: a) Resident #1 was seated at 11:35 AM and handed a menu at 11:40 AM. b) At this time there were 4 staff and 32 residents in the dining room. c) Resident #1's menu was picked up at 11:45 AM and placed on a table with other menus near the prepared steam table. d) Resident #1 was served a drink at 11:55 AM. e) 12:05 PM- 2 non-licensed staff were observed requesting lunch and being served. f) Resident #1 was served the meal at 12:20 PM, 35 minutes after placing the order. Per interview at 1:45 PM the Administrator stated staff are not supposed to eat before residents and the meal would be expected to be served sooner.	F 362	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F362 Staffing for meal service in the Main Dining Room will be reviewed and revised as needed by 7/30/10 to meet the resident needs in a timely manner. Resident #1 was interviewed regarding dining service on 7/26/10. The issues identified will be corrected honoring the resident's preferences by 7/30/10. Facility staff will be in-serviced by 7/30/10 to the facility policy regarding staff meals are only available before and after the residents meals have been served. The dietary manager or designee will complete random audits of resident meals, alternating breakfast, lunch and supper, 5 times a week for 3 months to ensure there is sufficient staff available to serve meals timely to the residents and staff are not served meals during resident meal service. Results of these audits will be reported the PI committee and changes will be made as needed. F362 POC Accepted 7/29/10 J. Hosmer RN | Pmcota RN	7/30/10
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	Continued From page 4 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain clinical records on each resident that are complete and accurately documented for 1 applicable resident (Resident #2). Findings include: Per record review and interview on 07/06/10, the clinical record for Resident #2 failed to have accurately documented weights. Per review of Resident #2's clinical chart, the nursing note dated 2/19/10 states, "R.D. (Registered Dietician) updated, suspect weight loss has occurred over several months to a year and questions inaccurate weights". In addition, the re-weights that were recorded on the 're-weight sheet' were not dated/signed. Per interview on 7/6/10 at 4:30 PM the R.D. confirmed that "the weights were not documented correctly and thought that the scale might have been off". Per interview at 5:15 P.M. the Administrator confirmed the clinical records were not complete and accurate.	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F514 Resident #2 was discharged from the facility on 5/27/10. Residents who currently reside in the facility have had their weights reviewed for accuracy which was completed on 5/21/10. Re-weights have been done as needed. New weight records for the residents were implemented on 5/21/10 which indicate date of the weight with the date of the re-weight. Random audits will be completed weekly by the dietitian or designee for 3 months to ensure weights are accurately documented in the medical record. Results of these audits will be reported the PI committee and changes will be made as needed. The administrator is responsible for monitoring. F514 POC Accepted 7/29/10 J-Hosmer RN/Pmeota RN	7/30/10